



Medical

Enrollment and Change Form

STEP #1

Check below to indicate plan enrollment

- ☐ Co-Pay Medical Plan (\$15/\$25 co-pay)
- ☐ Deductible Medical Plan (\$300 deductible)
- ☐ I Decline Medical Coverage

STEP #2

Check appropriate options

- ☐ New Enrollment ☐ Add Dependent
- ☐ Cancel Dependent ☐ Address Change
- ☐ Name Change:
From _____ TO: _____
- ☐ Open Enrollment
Change current medical coverage to _____
- ☐ Qualifying Event
☐ Marriage ☐ Divorce ☐ Birth ☐ Other _____

Enrollment due to a qualifying event requires proof validating the event

STEP #3

Complete Employee Information

- ☐ Board of Education Employee
- ☐ County Government Employee

Indicate the Department or School Location where you work: _____

Work Phone: _____ Home/Cell Phone: _____ Male or Female

Employee Name: _____ SS # _____ / _____ / _____ Date of Birth _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

(PCP) Primary Care Physician First, M.I., & Last Name: _____

*Required for enrollment in Co-pay medical plan only * If Known, Medical Group Affiliation: _____

STEP #4

Please list all family members to be enrolled or terminated

First, M.I., & Last Name		Social Security #	Birth Date	Sex	<u><i>This section only required if enrollment in Co-pay option</i></u>
					List Primary Care Physician and group affiliation if known First, M.I., & Last Name
	SP	/ /	/ /	M F	
	CH	/ /	/ /	M F	
	CH	/ /	/ /	M F	
	CH	/ /	/ /	M F	

If you are enrolling a spouse, the Spousal Insurance Information form must accompany this enrollment form.

Enrollment of a child over the age of 19, verification of eligibility must accompany this enrollment form.

STEP #5

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my pay check according to my above enrollment options.

Employee's Signature: _____ Date: _____

Williamson County Benefits Department use only: EE Hire Date: _____ / _____ / _____ Effect Date of Enrollment: _____ / _____ / _____
10/26/06 SBPA: _____ / _____ / _____ Initials: _____